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POLISH GUIDELINES FOR COSTING IN PHARMACOECONOMIC EVALUATION IN COMPARISON TO EXISTING GUIDANCE FOR COSTING IN OTHER COUNTRIES

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OBJECTIVES: Standardisation of costs is an important topic within the methodology of economic evaluation. National guidelines, that formulate the formal requirements for studies to be considered when deciding on the reimbursement of new medical therapies, are rather global with respect to costing. In an attempt to further standardise the costing methods some countries have issued additional guidelines for cost calculations. The aim of this study is to compare project of Polish guidelines for costing with existing international guidance, highlighting areas of agreement and dissent. **METHODS:** Existing guidelines for costing were reviewed, analysed and comparison between they and their Polish counterpart was subsequently undertaken. **RESULTS:** Guidelines for costing in pharmacoeconomic evaluations have been issued in Australia, Canada and the Netherlands. The Australian costing guide provides an extensive list with standard costs of hospital services. The use of these standard costs is obligatory in the case of formal appraisal studies for new medications. The Canadian guidance presents basic principles and methods only and does not yet present a standard cost list. The Dutch manual strikes the balance between guidance mentioned above and with the introduction of standard values and the way the standard costs are treated introduces some new elements to standardisation of costs in economic evaluations. In Polish project basic principles, methods for measurement and valuation and reporting of costs are described. The standard values and costs are presented and recommended for studies that support submissions to acquire reimbursement. Standard costs are calculated as weighted mean, maximum and minimum values based on available data from sick founds and are as patient- and disease-specific as possible. **CONCLUSIONS:** The guidelines for costing fit with current practice and the availability of data in each country. They contribute to the comparability and generalisability of economic evaluations and can deliver benefit for healthcare decision makers.

PHP17

SOURCES OF VARIATION IN DRUG COSTS AMONG STATE MEDICAID PROGRAMS

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OBJECTIVE: Drug spending is the fastest growing component of state Medicaid budgets. This study assesses the extent of state variation in Medicaid drug spending among all 50 states in 2001. **METHODS:** Data on Medicaid drug cost, users, and number of prescriptions were compiled for 2001 for all 50 states and evaluated by class and product. Levels of drug use and spending were compared across states and expressed on a per-user basis. **RESULTS:** Medicaid drug expenditures totaled almost $25 billion in 2001, more than double the outlay in 1996; drugs now account for approximately 12% of Medicaid spending. Nationwide, the top 5 drug classes (antipsychotics, antidepressants, gastrointestinal agents, anticonvulsants, and antivirals) accounted for 36% of drug expenditures, and the top 5 drugs accounted for 16% of total expenditures. The average cost per user was about $1200 across all states. This ranged from more than $2000 for Connecticut ($2732), New Jersey ($2159), and Rhode Island ($2130) to less than $800 for Delaware ($756), Texas ($743), Wyoming ($714), New Hampshire ($683), and Maryland ($616). The number of prescriptions dispensed rather than the average cost per prescription largely drove the differences in cost per user. The 10 states with the highest per-user cost averaged 33 prescriptions per user, compared to an overall average of 22, and an average of 15 for the bottom 10 states. The average cost per prescription was $53 for the 10 states with the highest per-user cost and $51 for the bottom 10 states. **CONCLUSIONS:** The number of prescriptions per user, and not the cost per prescription, drives a four-fold variation among states in the average prescription drug cost per beneficiary. Explanatory factors should be explored, such as population density, state drug cost containment strategies, disease epidemiology, and state health and social policies.

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INCREASED HEALTHCARE UTILIZATION FOR THE ELDERLY DUE TO INAPPROPRIATE PRESCRIPTION USE

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OBJECTIVE: Inappropriate prescribing can cause significant adverse events for all age groups. It perhaps would be most costly when it happens to the elderly in particular. Most existing studies explored the high prevalence and demographic variables as risk factors of inappropriate prescribing. This study examines the healthcare cost utilization outcomes of inappropriate drug use by the elderly at the national level. **METHOD:** Inappropriate medications were defined by well-accepted Beers explicit criteria. OLS and negative binomial models were employed to estimate the functions with different dependent variables using the 1996 Medical Expenditure Panel Survey (MEPS), a national representative sample of the non-institutionalized populations. In order to generalize the result to the whole US nation, complex survey sample design was adjusted in modeling. **RESULTS:** Compared with elderly using proper medications, inappropriate pre-